State of Vermont
Agency of Human Services

Global Commitment to Health
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Annual Report
for FFY 06
October 1, 2005 to September 31, 2006

DRAFT
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Table of Contents

Background and Introduction

The state of Vermont is a national leader in making affordable health care coverage available to low-income children and adults. Vermont was among the first states to expand coverage for children and pregnant women, through the implementation in 1989 of the state-funded Dr. Dynasaur program. In 1992, Dr. Dynasaur became part of the state-federal Medicaid program.

When the federal government introduced the State Children's Health Insurance Program (SCHIP) in 1997, Vermont extended coverage to uninsured and under-insured children living in households with incomes below 300 percent of the Federal Poverty Level (FPL).

In 1995, Vermont implemented an 1115(a) waiver program, the Vermont Health Access Plan (VHAP). That program's primary goal was to expand access to comprehensive health care coverage for uninsured adults with household incomes below 150 percent (later raised to 185 percent) of FPL, through enrollment in managed care. VHAP also included a prescription drug benefit for low-income Medicare beneficiaries who did not otherwise qualify for Medicaid. Both waiver populations pay a modest premium on a sliding scale based on household income.

On September 30, 2005, the Vermont Legislature, through its Joint Fiscal Committee, granted conditional approval for the State to begin implementation of the Global Commitment to Health Demonstration Program. The Legislature gave full approval for participation on the waiver on December, 13, 2005.

The Global Commitment to Health is a Demonstration Initiative operated under a Section 1115(a) waiver granted by the Centers for Medicare and Medicaid Services, within the Department of Health and Human Services.

The Global Commitment provides the state with the ability to be more flexible in the way it uses its Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g., case rates, capitation, combined funding streams) rather than fee-for-service, to pay for services not traditionally reimbursable through Medicaid (e.g., pediatric psychiatric consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). The managed care model will also encourage inter-departmental collaboration and consistency across programs.

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit an annual report 120 days following the end of each waiver year. The intent of these reports is to present a summary of the State's accomplishments, project status, findings, spending and challenges over the year." This is the first annual report for the new waiver which began on October 1, 2005.

Accomplishments

Fiscal & Operational Management: Development of the financial aspects of the waiver received significant attention during the first quarter of year one. A position was established in the Agency of Human Services fiscal office as the MCO Financial Administrator. This position is responsible for MCO fiscal monitoring and ensuring all AHS and MCO federal and state reporting requirements are met. The actuarial certification of the MCO premium ranges for the first waiver year was completed in mid-December of 2005. The actuarially certified rate range was established at $60,115,350 - $66,747,894 per month for the nine months of Waiver Year 1 that fell in State Fiscal Year 2006. CMS provided written approval of Vermont's actuarial methodology September 28th, 2006.

MCO Work Plan & Requirements: As an MCO, the OVHA must adhere to federal rules for Medicaid MCOs. In order to ensure compliance with federal regulations OVHA and AHS agreed on an MCO work plan which included activities that ranged from legislative rulemaking related to internal Grievance and Appeals process to member handbooks and provider directories. Accomplishments in the work plan include, but are not limited to,

- AHS-wide review, revision and the initiation of legislative rulemaking relative to MCO Grievance and Appeals requirements. Associated procedures will ensure consistency across all AHS departments and thus MCO operations to acknowledge and resolve service and benefit disagreements between beneficiaries and the MCO in a timely and fair manner.
- Establishment of Interpreter Services to provide oral interpreters free of charge to non-English speaking enrollees who request assistance.
- Creation of a web based provider directory which includes provider names, locations and telephone numbers for all primary care and specialist providers and hospitals participating in the Medicaid program. This web based directory allows individuals to search by address, provider type, etc.
- Identification of a work group to update and create a comprehensive enrollee handbook. This handbook will cover how to access care, enrollee rights, and responsibilities, procedures for obtaining benefits, what to do in a medical emergency and how to file a grievance or appeal. The target date for completion of the handbook is Spring 2007.
- Development of a process to identify providers who are terminating their practice and ensure notice to enrollees as needed.
- Establishment of information and direct web page link to statewide information on advanced directives.
- Establishment of a medical advisory task force to provide consultation for clinical practice guideline development and review.
- Development of procedures related to fraud and abuse detection that include but are not limited to: designation of a compliance officer in OVHA; completion of a compliance plan to guard against fraud and abuse including standards of conduct and staff training; implementation of a new automated fraud abuse detection system with EDS.
- Development of an initial utilization management plan.

Technical Assistance from CMS Regional Office: Vermont has relied on CMS regional staff for technical assistance in areas ranging from quality assurance and evaluation to fiscal reporting processes and formats. Regional staff have been very responsive, timely and helpful in providing technical assistance, supporting materials and helping Vermont understand and implement MCO requirements in the context of a state government system.

Collaborations with the Joint Fiscal Office: Processes have been put into place to develop consensus documents and agreements between the Executive and Legislative branches related to Global Commitment budgets, trends and projections. This detailed level of fiscal consensus building is the first of its kind between the branches of state government and has yielded a productive and collaborative discussion of the pressures on our public and private health care delivery systems.

Despite Vermont's changes in staffing and the challenges of competing healthcare demands (see section VI), the MCO made considerable progress in meeting MCO requirements under 42 CFR section 438. Both AHS and MCO fiscal monitoring and reporting obligations were met and the state fiscal year ended with modest savings in the demonstration program.

Project Status

At the close of year one, Vermont continues to work through MCO requirements and identification of AHS oversight and monitoring tools. In addition focused cross departmental operations groups have been working to understand MCO requirements relative to all aspects of the AHS system and to ensure the development consistent practices and reporting. A brief summary of work is outlined below.

General operations: The need for and AHS-wide cross departmental operations teams has been identified in at least four core areas. These include 1) Policy, 2) Operations, 3) Fiscal and 3) Quality Improvement. Each team is facilitated by an AHS and OVHA senior staff member and is composed of Deputy Commissioners and/or senior managers from departments and divisions impacted by Global Commitment. These teams are responsible for ensuring that necessary changes in internal operations occur related to the OVHA/MCO work plan, IGA commitments and other relevant state and federal regulations.

In the operations area, AHS Deputies and Directors are also in the process of identifying opportunities for programmatic flexibilities in two areas. First, program flexibilities within existing budgeted resources. Such as, for example, the integration of administrative structures for programs serving the same or similar populations are being examined with the goal being to increase access to services while decreasing administrative burdens created by programs operating, (pre-waiver), under separate AHS administrative and Medicaid reimbursement structures. Second, this group is developing criteria for the review of requests for expansion of existing programs or new requests for Medicaid program support.

In the Quality Assurance/Performance Improvement area, the group is charged with the development, integration, and maintenance of an AHS & OVHA quality strategy, generating AHS -wide quality standards for access to care, structure and operations, and quality measurement and improvement that comply with the Code of Federal Regulations 438.206 – 438.236. Additionally, this group will make recommendations to the Secretary's Office regarding the overall AHS direction related to quality and outcome measurement. The QA/PI Committee leverages the experience, expertise, and insight of AHS personnel whose job specifications include a special focus on Quality Assurance/Performance Improvement activities. As a result, the committee constitutes a cross-section of Quality Managers for

all AHS Departments and Divisions. Responsibilities and activities of the Committee include, but are not limited to: reviewing Federal Quality Standards and establishing AHS-wide Quality Standards and procedures; identifying and defining medical and non-medical outcomes that will be monitored by AHS/MCO; defining and recommending AHS-wide Performance Measures; and providing suggestions and recommendations for AHS-wide Performance Improvement Projects. During this quarter, the AHS Quality Improvement Manager also worked with OVHA and its sub-contracted departments/divisions to begin development of an inventory of current Performance Measures and Quality Improvement activities. The results will help to identify agency-wide quality measurement strengths and challenges, document gaps in performance measures and quality improvement projects and help inform the written Quality Strategy.

External Quality Review: As a result of the new Global Commitment (GC) to Health Waiver, and after discussion with CMS, Division of Mental Health (DMH), and Office of Vermont Health Access (OVHA), the focus of the EQRO will be broadened in year two to include all Medicaid recipients and oversight will be transferred from OVHA to AHS.

Quality Strategy: CFR section 438.202 Subpart D outlines five State responsibilities for a Quality Strategy. One of the five requirements is a written strategy for assessing and improving the quality of managed care services. Vermont has reviewed the CMS standards for access, structure and organization, and measurement and outcome, as well as CMS approved Quality Strategies from various states in preparation for developing and implementing a quality strategy in year two.

Evaluation Activities: The Draft evaluation plan is under review and revision. The overall purpose of the evaluation is to measure the degree to which identified performance measures changed as a result of the demonstration. As a result, the evaluation will answer the following questions: to what degree did the demonstration achieve its purpose, aims, objectives, goals and quantified performance targets; what lessons were learned as a result of the demonstration; in what ways were outcomes for enrollees, providers, and payers changed as a result of the demonstration; and did the reallocation of resources in the demonstration generate greater "value" for the state's program expenditures?

MCO work plan: At the close of the first year AHS and MCO staff are in the process of filing the necessary state and legislative paperwork required in order to revise relevant AHS and MCO grievance and appeal regulations. Filings are expected the first quarter of year two and public hearings and comment on the proposed grievance and appeal rule changes expected January of 2007. In addition work continues on all other aspects of the work plan (see Attachment A).

Healthcare Reforms & Benefit Changes: During the second quarter of the year, the Vermont FY07 Budget Act and the Vermont Health Care Affordability Act became effective (July 1, 2006). This legislation contained the following changes regarding cost-sharing amounts, eligibility and benefits:

- *VHAP-ESI* – The new laws propose to implement an Employer Sponsored Insurance (ESI) program for both existing and new VHAP enrollees. Beneficiaries will be held harmless in terms of cost and benefits compared to the regular VHAP program. The savings generated by this initiative will be used to finance coverage for additional low-income, uninsured Vermonters.
- *ESI Premium Assistance Program* – Vermont intends to make coverage more affordable for uninsured individuals with incomes up to 300 percent of FPL. Individuals who have access to coverage through their employers will have the opportunity to participate in the ESI Premium Assistance Program. Public subsidies will be available under this program to help cover the employee share of monthly premiums for employer-sponsored coverage.

- *Catamount Health Assistance Program* – Catamount Health is a broad initiative designed to make affordable commercial coverage accessible to individuals unable to obtain coverage through their employers. Covered benefits will be defined by the State and provided through commercial carriers. Catamount Health will be available to all Vermonters, regardless of income. The Catamount Health Assistance Program would provide for public subsidies toward the premiums paid under Catamount Health. The Catamount Health Assistance Program will be available to low-income uninsured Vermonters with incomes up to 300% of the FPL, who do not have access to employer-sponsored insurance that is more cost-effective for the State.
- *Recertification Requirements* – Vermont currently recertifies eligibility for certain groups at six-month intervals, while recertification occurs every twelve months for other eligibility groups. Vermont intends to modify the program requirements for VHAP, Dr. Dynasaur and other eligibility groups to require recertification every twelve months. This modification also helps to offset the operational resource demands resulting from the new citizenship verification requirements.
- *VHAP Eligibility Requirements* – Vermont intends to modify existing rules in order to extend eligibility to Vermont residents who are college students and have taken medical leave.
- *Enrollee Premiums* – In order to promote access to affordable health coverage, the law requires that VHAP premiums be reduced by 35% and Dr. Dynasaur premiums be reduced by 50% beginning July 1, 2007.
- *Chronic Care Management* – The centerpiece of Vermont's efforts to reengineer the health care delivery system, improve quality and lower costs is to create a statewide system of care for individuals with chronic conditions—conditions that constitute more than 75% of our total health care spending. There are multiple approaches within the new laws that converge to achieve this statewide chronic care system, including expansion of the state's Blueprint for Health, a requirement that the Catamount Health Plans have a chronic care management program consistent with the Blueprint, and a chronic care management system to manage the chronic conditions of individuals enrolled in Medicaid, VHAP and Dr. Dynasaur.

Vermont submitted a waiver amendment request to CMS on September 11, 2006 to operate those initiatives that require CMS approval within the framework of our approved Global Commitment to Health 1115(a) Demonstration (see Attachment B). The program will be managed within the existing financial terms and conditions, so the request is for programmatic approval. We have begun informal discussion with CMS regional and central office staff, and supplemental information will be submitted December 8th 2006. We look forward to January 2007 discussions with CMS regarding our request and its approval.

Quantitative and Case Study Findings

Waiver year one involved start up and creation of MCO and AHS work plans to implement the necessary wavier monitoring, reporting and required MCO program changes. Additionally, work on our quality strategy and overall waiver evaluation has been delayed by the staffing and other difficulties reported in section 6 of this document. As such it is premature to report on specific case study findings or quantitative data. However, one initiative utilizing the flexibility granted by the Global Commitment to Health Waiver includes OVHA's Care Coordination Program (CCP). Specifically, OVHA is committed to partnering with primary care providers, hospitals, Agency of Human Services (AHS) departments, and community agencies to address the need for enhanced coordination of services in a climate of increasingly complex health care needs and scarce resources.

The CCP facilitates the beneficiary-provider relationship by offering services that assist providers in tending to the intricate medical and social needs of beneficiaries without increasing the administrative burden. The CCP supports providers by providing intensive case management to the beneficiary between visits to enable the plan of care to be successful. Ultimately, the CCP aims to improve health outcomes, decrease inappropriate utilization of services, and increase appropriate utilization of services.

Outlined below is a brief description of the CCP, start-up status and accomplishments in waiver year one.

Method: The CCP focuses on Medicaid's highest utilizers with chronic conditions, approximately 1,200 beneficiaries statewide annually. As supported by the Chronic Care Model, the CCP emphasizes evidence-based, planned, integrated and collaborative care for Medicaid beneficiaries who exhibit high-prevalence chronic disease states, high-expense utilization, high medication utilization, and/or high emergency room (ER) and inpatient utilization.

Implementation: Medicaid beneficiaries who will most benefit from the CCP are selected based upon criteria identified through claims data and in collaboration with their primary care provider. Regionally-based Care Coordination teams [one Registered Nurse (RN) and one social worker] work with the beneficiary, their provider(s), community based organizations, and State entities to devise a tailored care plan through assessment of current treatments, services, and resources. Care Coordination teams access resources from many avenues, especially Vermont Blueprint for Health-related activities, to enable the beneficiary to obtain better self-management skills and empower the beneficiary to promote their own health and well-being.

During calendar year 2006, the OVHA hired and deployed a Field Director, an Associate Medical Director, three RNs and three social workers.

The Agency of Human Services (AHS) reorganization recognized the need for coordination of services at the community level. As such, Care Coordination teams are located at the local district offices to provide a unique and critical aspect of the AHS support network and to establish relationships with primary care providers that are focused on health outcomes. Care Coordination teams are informed about local and statewide quality improvement initiatives and are able to assist providers to access these initiatives. The result of locally-based Care Coordination teams is the opportunity to collaborate creatively to address the unique needs of an individual beneficiary. To-date, this collaboration has been very rewarding for both beneficiaries and the OVHA.

The CCP has begun to make significant contributions towards achieving the goals of the Vermont Blueprint for Health by addressing the unique characteristics of the most complex Medicaid beneficiaries and the challenges those with chronic conditions face in participating fully within the Blueprint. Many beneficiaries need additional support to become the "…informed, activated patient" that the model describes. Care Coordination teams provide additional support by facilitating the implementation of the essential components of disease management programs , as identified by Dr. Kenneth Thorpe, such as team-based care, cross-consortium coordination, patient education, outreach and care management. Because Care Coordination teams are locally-based, they are able to implement these components within the context of the beneficiary's community, taking into account what is available and acceptable to the beneficiary and their primary care provider.

Current Participating Providers, Agencies and Stakeholders: As of January 2007, the participating providers, agencies and stakeholders include:

1) Barre Health Center
2) Berlin Health and Rehabilitation
3) Central Vermont Community Partnership
4) Central Vermont Hospital (CVH)
5) Central Vermont Physician Practice Corp. (CVPPC)
6) Central Vermont Substance Abuse Services
7) Community Health Center of Burlington
8) Corner Medical
9) Department for Children and Families (DCF) - field service districts
10) Department of Disabilities, Aging and Independent Living (DAIL)
11) Evergreen Family Health
12) Fletcher Allen Health Care (FAHC)
13) Health Center of Plainfield
14) Howard Center for Human Services
15) Northeast Kingdom Human Services (NEKHS)
16) Northeastern Vermont Area Health Education Center (NEVAHEC)
17) Northeastern Vermont Regional Hospital (NVRH)
18) Northern Counties Health Care (NCHC)
19) Planned Parenthood of Northern New England
20) Professional Nurses
21) Vermont Association of Hospitals & Health Systems (VAHHS)
22) Vermont Department of Health offices in St. Johnsbury, Barre, and Burlington
23) Visiting Nurse's Association (VNA)
24) Vocational Rehabilitation Services
25) Washington County Mental Health
26) Wellness on Wheels
27) Winooski Family Health

Integration with the Chronic Care Management Program (CCMP): The OVHA's Chronic Care Management Program (CCMP) is designed to address the needs of Medicaid beneficiaries with more moderate needs on a continuum extending downward from the CCP population. Beneficiaries will be transitioned into the CCMP from the CCP when they are no longer in need of such intensive case management. It is anticipated that there will be fluidity between the CCP and CCMP as beneficiaries move up and down the health needs continuum and transition between the CCP and CCMP. Population selection and monitoring assistance for both the CCP and CCMP will be done by the Center for Health Policy and Research at the University of Massachusetts Medical School contracted under the CCMP.

Provider Payments As Part Of CCP: A segment of the operating costs for the CCP are set aside for reimbursing participating providers. A strategy has been developed to reimburse the providers with an enhanced capitated payment rate of $15 per month for a CCP patient. To emphasize the importance of developing a plan of care with the primary care provider, the OVHA will also reimburse the provider $50 for meeting with Care Coordination teams when one of their patients is enrolled in the CCP. Providers will also be reimbursed $50 for a "discharge" meeting to emphasize the importance of a smooth transition when a participant leaves the CCP.

The combination of incentive payments for meetings and an enhanced case management fee, $10 more than the PC Plus case management fee, provides primary care providers with an attractive incentive for participation in the CCP.

Achievements To-Date: As of September 31, 2006, 156 beneficiaries have received Care Coordination services.

1) Caledonia County, Washington County and Chittenden County teams are actively enrolling beneficiaries.
2) A consultant pharmacist has been hired to assist the Care Coordination teams with medication questions.
3) Two social workers have been identified for Franklin and Lamoille Counties.
4) Care Coordination teams have attended numerous trainings, including *Bridges out of Poverty* and *Foundations*.
5) Community and local outreach has been successful and well received.
6) Hospital outreach has been successful and well received in all three counties.
7) Claims data has been refined and organized for maximum use.
8) A Care Coordination Orientation Manual and Program Manual has been drafted.
9) Standard Care Coordination methodology has been established.
10) The OVHA's Information Technology (IT) Unit has developed a case management system for tracking Care Coordination Program participants.
11) Intermediary and final outcomes have been established.
12) Meetings with Blueprint staff have occurred to enhance alignment and consistency.
13) A reimbursement strategy has been devised to encourage providers to participate in the Care Coordination Program.
14) Multiple AHS departments and OVHA units have collaborated to ensure the successful implementation of the Care Coordination Program.

Utilization Data

The state has initiated several different mechanisms to verify encounter data. First, the Medicaid Surveillance and Utilization Review System (SURS) Team within OVHA is charged with reviewing high utilization of Medicaid services by individuals and/or providers. This includes: routine claims evaluation activities to identify unusual patterns in billing activity; routine provider performance review activities to identify administrative claims errors, misuse, and/or abuse; routine beneficiary reviews to identify overuse, under use, and/or aberrant behavior; ad hoc provider specific auditing; ad hoc beneficiary specific utilization auditing; and annual reporting of findings and recommendations. Second, Vermont has field tested and adopted a Fraud Abuse Detection Decision-Support System (FADS) that will interface with the EDS claims system to provide electronic data reports to the SURS Team for their analytical use.

Utilization data for FFY06 relative to emergency room, inpatient services and preventative medicine services is outlined below.

Federal Fiscal Year (FFY) 2006
Utilization Data

	Total Visits	Average Members	p/1000
ER Visits	62,268	103,724	600.32
Inpatient Days	50,010	103,724	482.14
Inpatient Admissions	10,613	103,724	102.32
Preventive Medicine Services	56,618	103,724	545.85

* All data exclude Pharmacy Only Eligible's and Dual Eligible's

Federal Fiscal Year (FFY) 2006 Utilization Data by Eligibility Group						
	Average Members	ER Visits p/1,000	Days p/1,000	Admissions p/1000	Average Length of Stay	Preventive Medicine Services p/1,000
ABD - Non-Medicare - Adult	11,343	1,204.91	1,282.05	205.24	7.25	326.55
ABD - Non-Medicare - Child	2,470	848.35	1,000.20	140.92	8.10	648.31
ANFC - Non-Medicare - Adult	7,095	1,305.75	1,120.83	398.04	3.82	249.06
ANFC - Non-Medicare - Child	39,023	562.41	326.01	70.19	5.64	1,087.96
GlobalExp	16,787	890.85	681.88	135.88	6.02	400.72

The second quarter report noted that OVHA's release of a Request for Information (RFI) for an on-line decision support system had been issued. Soon after the RFI release, a decision was made to table the project pending the release of a Request for Proposals to implement two pivotal initiatives; the Chronic Care Management Intervention Services and the Health Risk Assessment Administration. It is anticipated that any vendor bidding on either of those projects will also be providing a decision support system that OVHA will be utilizing in its related care coordination projects.

In addition to these activities, OVHA has created a Program Integrity Unit; position requests were improved during the third quarter of the waiver year and are actively being filled. Staffing of a complete unit will bring together the Medicaid Surveillance and Utilization Review System (SURS) Team, the Fraud Abuse Detection Decision-Support System (FADS) reporting, overall OVHA and AHS utilization review and investigative functions.

AHS continues work on developing "release 2" of the Coverage and Service Management Enhancement (CSME) Data Warehouse, renamed the "Central Source Measurement and Evaluation Data Warehouse". CSME data are structured to answer questions across departments for policy, planning, legislative and program review. "CSME Release 2" will allow policy analyst and AHS research staff to continue data validity testing while work on the addition of new data source systems are prioritized, timelines developed and security tools are put into place.

Policy and Administrative Difficulties

Unanticipated Delays in Implementation: During the second quarter of year one, a significant amount of staff time and effort was directed towards addressing the implementation issues that have arisen with the pharmacy changes under the Medicare Modernization Act. Within 48 hours after implementation of the federal program, Vermont recognized the need to re-instate the state program to ensure that beneficiaries received their medications in a timely manner. Because of the operational complexity of this program, OVHA staff and others within AHS used to spend significant amounts of time on MMA which in turn caused significant delays on some of the operational issues identified in the MCO work plan.

Additionally, changes in key AHS leadership were made in the second and third quarters that involved the appointment of a new Secretary and Deputy Secretary of the Agency of Human Services, Cynthia LaWare and Steven Gold, respectively, and a new Agency of Human Services Global Commitment lead, Suzanne Santarcangelo. By the fourth quarter a new AHS Quality Improvement Manager, Shawn Skaflestad, was hired to begin work on both the development of a quality strategy and the overall evaluation of the demonstration project activities. Shortly following the close of the year two other key staff accepted positions in other areas of AHS. The MCO Financial Administrator and the AHS Chief Fiscal Officer positions will be under recruitment in the first quarter of waiver year two.

Understanding of Implementation Issues Across AHS and MCO programs: For the past 15 years, Vermont's program development and operational strategy for many social, behavioral, and related educational services has been to maximize federal revenue streams. Now, under Global Commitment, the most difficult adjustment for AHS managers and community partners has been to understand that the main Medicaid revenue streams are capped. For many this has little functional impact while for others it is a complete shift from their typical program development strategies. One area of substantial impact is how AHS has traditionally authorized spending for Medicaid services, on a "fee-for-service" basis. Many social services and behavioral health programs have been funded or expanded by increasing some new federal Medicaid funds when an agency program or community partner was delivering Medicaid eligible services to Medicaid eligible individuals. All that was needed was the availability of State General Fund dollars or otherwise unencumbered local (non-federal) monies to match increased federal Medicaid funds. Under the capped environment of Global Commitment to Health Waiver, the program development strategy of maximizing the use of federal funds must be reviewed in relation to all other demands and priorities. It must then be managed such that Vermont stays within the agreed upon cap.

Cross Departmental Nature of Implementation: One particular challenge for programs is that rather than living under and managing separate and discrete caps, all Medicaid programs live under one cap; therefore the impact of a change in Medicaid allocation in one area immediately ripples across all areas. Each department's spending is more directly and immediately interrelated with all other's spending. Closely related to this is the challenge of managing growth across programs that grow unevenly or unpredictably and across the two largest (budget-wise) Agencies of state government (AHS and DOE). This includes managing federal entitlements which cannot be limited along side discretionary and state mandated spending.

Other areas of impact include the internal fiscal mechanisms (i.e., monitoring, reporting and interdepartmental transfers) that AHS has historically used to manage interagency or multi-departments agreements for highly specialized situations. In many cases these internal processes need to be revised.

Decisions in one Medicaid arena are now inextricably linked and have an immediate and direct impact on every other area of Medicaid. The centralized support functions put into place as a result of AHS reorganization (Information technology infrastructure, fiscal oversight, human resource development, AHS-wide policy guidelines, etc.) are still developing and need to be fully realized. Agency-wide prioritization, reporting and monitoring of fiscal, service and program outcomes have begun and must become standard practice.

Developing MCO compliance, quality standards and other activities in the context of State Government Agencies. In most cases meeting the MCO requirements involve changes in internal procedures under the control of AHS or its member departments. In other areas, such as grievance and appeals, the revisions involve state regulatory/rulemaking processes which can be more lengthy and involved within the state government and legislative systems. Both processes can be inherently time consuming.

Relative to internal changes, the AHS has not historically had the centralized support functions to shepherd agency-wide consistency in practice and procedures. Cross departmental collaboration over certain initiatives or individual customer situations was typical, however operational structures, quality assurance and improvement activities, and reporting and tracking of services, fiscal, and program outcomes have varied considerably across the AHS. The 2004 Reorganization of the AHS set the

foundation for more consistent and cohesive agency wide practices; however by the start of the waiver in October 2005 many of the centralized support functions were still being formed. Within the first waiver year it has became more evident that a variety of fiscal and operational practices need revision and need to be more consistent across the various programs.

Financial planning and budgeting has been particularly challenging. Pre-waiver, many programs operated under separate and discrete waivers or other appropriations. Budgets were historically built by individual departments and combined into one overall AHS budget. Post waiver, all Global Commitment related expenditures and projections need to be combined into a single agency wide global commitment budget and the entirety of the budget needs to be built before prioritization across the agency and with individual departments can occur. The Global Commitment budget is then overlaid into the non-Global Commitment budget, cross walked with historical categories of individual departments and one total AHS budget created.

Just as AHS needs to view Global Commitment across all departments as one budget, so does the rest of state government and the legislature. Work with the State Finance and Management Office as well as Vermont's Legislative Joint Fiscal Office pre-Global Commitment involved individual departmental budgets, appropriations, trends and projections. Post Global Commitment a process has been put into place to develop consensus documents and agreements between the Executive and Legislative branches on whole of Global Commitment. This detailed level of consensus building is the first of its kind between the branches of state government, and while initially a more consuming process, has yielded a much more productive and collaborative discussion of the pressures on our public and private health care delivery systems.

This new level of interrelatedness within the Medicaid program, while challenging, gives Vermont additional incentive to support and fully realize the benefits of Agency of Human Services Reorganization. Specifically, the Legislature concluded that prior to reorganization the Agency was not designed to address multiple interrelated needs; in fact the then design hindered efforts to affect coordinated policy and consistent practices. Further they suggested that the design did not promote the most effective and efficient allocation of financial and staff resources. Some of this inefficiency was driven by departments and providers needing to respond to the, at times, conflicting requirements of the various Medicaid funding streams and billing options available to them or the populations they served.

The inter-relationships and flexibilities that are created under Global Commitment have the potential to streamline or potentially eliminate the multiple billing and documentation requirements that currently exist. Developing more streamlined fiscal and management strategies align closely with principals of reorganization which included, in part, that the Agency structure and practices:

- support a holistic approach to serving individuals and families and ensure the coordination of services when multiple interrelated needs exist.
- ensure the efficient and effective allocation of financial and staff resources;
- establish effective data collection systems to support ongoing assessment of service quality and enhance continual organizational improvement;
- ensure maximum communication and collaborative planning when more than one service is being provided to a single consumer or family.
- provide a continuum of services capable of adapting and responding to changing needs and unique situations, including transitional stages.

The Agency continues to promote a unified management approach as we facilitate a variety of senior leadership and management meetings and ad hoc work groups to work on cross-cutting operational,

fiscal, quality improvement and outcome issues. Managers are being held accountable for identifying and recommending changes that can be implemented across the agency to:

- create more efficient administrative processes and requirements;
- identify and eliminate duplicative business processes, program monitoring and reporting requirements;
- create more efficient funding mechanisms and contractual options (e.g., capitated rates, pay-for-performance and/or outcome based contracts);
- prioritize program development or expansion initiatives;
- ensure compliance with federal MCO and other waiver requirements.

Further, senior managers are being asked to review proposals for program service delivery innovations generated by staff or community partners and make recommendations to the Agency Secretary's Office for prioritization and action.

In addition to administrative and management practices the Global Commitment to Health Wavier offers opportunity to fund health care delivery approaches that address the full continuum of prevention, early intervention and treatment. These efforts are showcased in several new systems initiatives, including OVHA's Chronic Care Coordination and Chronic Care Management Projects and the public/private partnership of Vermont's Blueprint for Health.

While the direction is becoming clearer and much work has been undertaken, many infrastructure changes and enhancements need to be completed to fully realize the promise of Global Commitment.

Capitated Revenue Spending

Please note, the chart below outlines the actual spending through State fiscal year 06 (June 30,2006) and estimated spending for the first quarter of state fiscal year 2007 (i.e., federal fiscal year 2006, the last quarter of wavier year one).

Federal Fiscal Year (FFY) 2006 (last quarter FFY06 is estimated spending)			
	Premium	**Member Months**	**Total Per MEG**
ABD - Non-Medicare - Adult	$1,116.45	183,382	$204,736,833.90
ABD - Non-Medicare - Child	$1,772.18	39,681	$ 70,321,874.58
ABD - Dual - 10/05 - 12/05	$1,264.65	37,600	$ 47,550,840.00
ABD - Dual - 1/06 - 6/06	$ 989.11	115,617	$114,357,930.87
ANFC - Non-Medicare - Adult	$ 493.53	110,458	$ 54,514,336.74
ANFC - Non-Medicare - Child	$ 299.38	626,947	$187,695,392.86
GlobalExp	$ 342.14	269,239	$ 92,117,431.46
GlobalRx - Non-Medicare - 10/05 - 6/06	$ 217.78	675	$ 147,001.50
GlobalRx - Dual - 10/05 - 12/05	$ 217.78	31,801	$ 6,925,621.78
GlobalRx - Dual – 1/06 - 6/06	$ 6.75	94,048	$ 634,824.00
OptionalExp	$ 151.24	14,982	$ 2,265,877.68
Totals		1,524,430	$ 781,267,965

Investments made by the MCO totaled an estimated $57,275,542 which represents actual spending through State fiscal year 2006 (June 30, 2006) and estimated spending for the first quarter of state fiscal year 2007 (i.e., federal fiscal year 2006, the last quarter of wavier year one).

Attachment A

MCO Work Plan

4th Quarter Report: MCO Work Plan (revised 10/31/06) **AREA/ DESCRIPTION**	**TASKS**	**TIMELINE**
MEMBER SERVICES		
Interpreter Services		
Oral interpreter services must be provided free of charge to non-English speaking enrollees who request assistance. [438.10(c)(4)]	Arrange for vendor to provide services as needed	Completed
Provider Directory		
A directory must be compiled and maintained. The directory must list the name, location and telephone numbers for all primary care and specialist providers and hospitals participating in the Medicaid program. The directory must also identify any languages other than English spoken by the provider and must include an indicator to identify those who are accepting new patients. [438.10(e)(2)(ii)(D)]	Develop web-based directory with ability to search by address, provider type, etc.	Completed August 2006:
	Survey providers on language capacity and open panel issues	Completed
	Develop process for periodic updates (web-based format allows for immediate updates).	Completed
Notification of Terminating Providers		
OVHA must notify an enrollee whose PCP terminates their participation in Medicaid within 15 days of the provider's notice to the state. Enrollees who are regularly seeing a provider who is not their PCP must also be similarly noticed. [438.10(f)(5)]	Develop process for identification of terminating providers	Completed
	Draft notice to enrollees	Completed
	Identify process for determining which enrollees have been "regularly treated" by any terminating provider	1st quarter FFY'07
	Print and mail notices within 15 days to affected enrollees	Completed
Enrollee Handbook		
Develop and maintain a current enrollee handbook which covers how to access care, enrollee rights and responsibilities, procedures for obtaining benefits, what to do in a medical emergency and how to file a grievance or appeal. Handbooks must be distributed to new enrollees within 45 days of enrollment. Handbooks must be available in languages other than English if five (5) percent or more of Demonstration enrollees speak that language. [438.10]	Assess need for languages other than English (documentation for CMS)	Completed for PCP and CRT enrollees AHS-wide work group established and meeting for all other enrollees Target date for completion: Spring 2007 (on schedule)
	Draft handbook	
	Disseminate for input, finalize based on comments received	
	Print a supply for initial distribution	
	Develop and execute handbook distribution process on an ongoing basis	
	Post handbook on website	
Advance Directives		
OVHA must prepare and make available information on Advance Directives. [438.6(h)(2)(i)]	Identify materials related to new 2005 state statute regarding Advance Directives	Completed: Link to new statewide information on EDS and OVHA web-page; Providers notified, also sent to enrollees on request.
	Obtain a supply of forms for distribution upon request	
	Post information on website	
	Draft informational notice on Advance Directives and distribute for posting in physicians' offices (EDS Newsletter)	

Member Helpline		
OVHA must maintain a toll-free member hotline during normal business hours to answer enrollee inquiries and to accept verbal grievances or appeals. [438.406(a)(1)]		Completed
GRIEVANCES & APPEALS		
Notice of Adverse Action		
OVHA must provide a written Notice of Adverse Action to each enrollee and their requesting provider of any decision to deny a services authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice must be sent within 14 days of the receipt of the request for services, unless that timeframe might, in the opinion of the requesting provider, seriously jeopardize the enrollee's health. In the latter event, the notice must be sent within three (3) business days of the request. [438.210l]	Develop one Agency Policy for all GC enrollees	New policy drafted; finalized and approved by CMS
	Change administrative rules to reflect new policy	Formal Legislative Rule-making begun October 2006 (on schedule)
	Draft notice to include appeal rights, information on the continuation of benefits, and how to request an expedited appeal	In process: new policy implemented Spring, 2007
	Develop policies and procedures for processing requests	
	Design notice inserts that describe the various reasons for the denial or reduction in services (e.g., not medically necessary, not a covered service, etc)	
Acknowledgement of Appeal		
Grievances and appeals must be acknowledged in writing (typical standard is within five business days).	Develop notices	In process: new policy implemented Spring, 2007
	Develop policies and procedures for ensuring notices are sent timely	
	Develop process and assign staff to assist enrollees in filing grievances and appeals	
	Assign staff to receive, date stamp and log in all grievances and appeals	
Resolution of Grievances and Appeals		
OVHA must have a formal process for resolving all grievances and appeals. Providers must be permitted to file grievances or appeals on behalf of their patients if so requested. The following definitions apply: ***An Action means –*** *1) The denial or limited authorization of a requested service, including the type or level of services; 2) The reduction, suspension or termination of a previously authorized service; 3) The denial, in whole or in part, of payment for a service; 4) The failure to provide services in a timely manner (as defined by the state); 5) The failure of the public MCO to act within prescribed timeframes.* ***An Appeal means –*** *Any request for a review of an action.* ***A Grievance is –*** *An expression of dissatisfaction with any matter other than an action (e.g., quality of care) [438.400(b)]. Resolution Timeframes: Standard Grievance – 45 days from date of receipt ([438.408(b)(1)]*	Develop policies and procedures for the receipt, acknowledgement and resolution of grievances and appeals	In process: new policy implemented Spring, 2007
	Develop a system for logging and tracking grievances and appeals (type, days to resolution, outcome)	
	Develop a system for automated reporting on grievances and appeals	
	Assign staff to process all grievances and appeals	
	Design resolution notices	

=90days); Standard Appeal – 45 days from date of receipt [438.408(b)(2)]; Expedited Appeal – Three (3) business days from date of receipt [438.408(b)(3)]		

Fair Hearings		
OVHA must ensure that enrollees have the right to request a fair hearing within no less than 20 days or more than 90 days from the date of the notice of resolution of the grievance or appeal. [438.408(f)]. AHS, as the oversight entity, must ensure that the fair hearing is conducted in accordance with all applicable state and federal regulations including timeframes for the conduct of the hearing and the enrollee's due process rights.	Develop policies and procedures for coordinating between the Grievance and Appeals process and the state Fair Hearing process	In process: new policy implemented Spring, 2007
	Develop a system for notifying enrollees at the time of the resolution of their grievance or appeal of their right to a fair hearing	
	Develop reporting system to track number, types, timeliness and resolution of fair hearings	
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI)		
QAPI Plan		
AHS must develop a strategy and plan which incorporates procedures that: 1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees, including those with special health care needs [438.204(b)(1)]; 2) Identify the race, ethnicity and primary language spoken by each Demonstration enrollee [438.204(b)(2)]; 3) Provide for an annual, external independent review of the quality outcomes and timeliness of, and access to, the covered services under the Demonstration [438.204(d)]	1) Develop inventory of all QA/QI activities currently underway within OVHA and sub-contracted departments; Develop workgroup to identify new priorities; 2) Summarize into comprehensive QAPI Plan for CMS review	1st Quarter , FFY07 2nd Quarter FFY07
	3) Ensure that information is available in ACCESS eligibly system	December, 2007
	4) Expand EQRO focus beyond CRT program	Completed
Source of Primary Care		
OVHA must ensure that each Demonstration enrollee has an ongoing source of primary care. [438.208(b)(1)] It must further implement mechanisms to identify persons with special health care needs. [438.208(b)(4)(c)] The quality strategy must specify these mechanisms. [438.208(b)(4)(c)(i)]	Identification of beneficiaries not already participating through PCPLus	March 2007
	Develop policies and procedures for the selection of a PCP by each Demonstration enrollee	Completed for current PCPlus
	Design information system capacity to capture the PCP information for each enrollee	Completed
	Develop a mechanism for tracking PCP caseload	Completed
Practice Guidelines		
OVHA must adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field, and which are adopted in consultation with contracting health care professionals. [438.236(b)]	Establish a medical advisory task force of contracting professionals to provide consultation on the guidelines to be adopted for physical health issues	Completed
	Select key areas where guidelines are to be developed	Completed
	Research evidence-based guidelines and protocols for each of the key areas	Completed

	Adopt the appropriate guidelines after consultation with the task force	Completed for existing guidelines; on-going identification of new national practice guidelines
	Distribute guidelines to appropriate network providers	Completed
Measuring Performance Improvement		
AHS must operate its QAPI program on an ongoing basis and conduct performance improvement projects designed to achieve, through ongoing measurement and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Procedures must be in place to collect and use performance measurement data and to detect both under- and over-utilization of services. Mechanisms must also be in place to assess the quality and appropriateness of care furnished to enrollees with special health care needs. [438.240(a), (b), (c), & (d)]	Develop inventory of all QA/QI activities currently underway within OVHA and sub-contracted departments;	1st Quarter , FFY07
	Develop workgroup to identify new priorities;	
	Summarize into comprehensive QAPI Plan for CMS review	2nd Quarter FFY07
PROGRAM INTEGRITY		
Actuarial Certification of Capitation Rates		
AHS must provide CMS with an actuarial certification of the capitation rates that will be used as the basis of payment of Medicaid funds to the health plan. The rates must be certified by an actuary who meets the standards established by the American Academy of Actuaries. [438.6(c)(4)(i)]	Develop database for actuaries	In process for Year 2 rates
	Establish capitation rates by MEG	
	Obtain written certification from qualified actuary	
	Submit rates to CMS	
Compliance Plan		
OVHA must also have administrative and management arrangements and/or procedures, including a mandatory compliance plan, that is designed to guard against fraud and abuse. This includes written policies, procedures and standards of conduct. A compliance officer must be designated and a compliance committee formed that is accountable to senior management. An effective training and education program must be developed and implemented for the compliance officer and other VHAP employees. [438.608(a) &(b)]	Appoint compliance officer	In substantial compliance with major expansion of activities planned
	Develop written compliance plan	
	Develop policies and procedures for program integrity	
	Develop written standards of conduct	
	Design staff training program	
	Conduct staff training	
MONITORING		
Utilization		
OVHA must monitor the program to identify potential areas of over- and under-utilization. Where such over- or under-utilization is identified, OVHA shall develop a Corrective Action Plan (CAP) for review by the AHS. [438.240(b)(3)]	Develop an overall utilization management plan for the Demonstration	Completed with ongoing activities through new Program Integrity Unit and FADS
	Identify key areas for monitoring (e.g., inpatient days, emergency visits, etc)	
	Establish thresholds for evaluating potentially inappropriately high or low levels of utilization by MEG	

Provider and Enrollee Characteristics		
OVHA's health information system must track certain characteristics of its network providers and enrollees (e.g., enrollees with special health care needs; providers with accommodations for the disabled in their offices) [438.242]	Identify outstanding issues in ACCESS and/other systems related to capturing required enrollee characteristics	1st Quarter, FFY'07
	Ensure that Provider survey captures required information and is in on-line directory	
Enrollee Rights		
Establish policies and procedures on enrollee rights consistent with the requirements of Part 438.100 of 42 CFR.	Expand existing PCP and CRT policies and procedures	Completed for PCP and CRT enrollees; available through enrollee handbook for all enrollees by September, 2007
Encounter Data Validation		
OVHA must put in place a process for validating encounter data and for reporting information on encounters/ claims by category of service. [438.242]	Expand existing processes to include sub-contracted departments.	Completed
	Implement new Fraud and Abuse Detection Decision Support System (FADS)	
ENROLLEE ACCESS & PROVIDER NETWORK		
Availability of Services		
OVHA must ensure that an adequate network of providers to provide access to all covered services is under contract to the state. This includes an assessment of geographic location of providers, considering distance and travel time, the means of transportation ordinarily used by Medicaid enrollees and whether the location provides for physical access for enrollees with disabilities. The assessment must also consider the number of network providers who are NOT accepting new Medicaid patients. OVHA must also ensure that network providers offer hours of operation that are no less than those offered to other patients. OVHA must also subcontract with other selected AHS departments that will provide services to Demonstration enrollees. [438.206]	Conduct geo-access analysis of current network	September 2006 and on-going
	Identify any existing gaps	
	Recruit additional providers as needed	
	Develop process and procedures for provider site visits if warranted	
	Develop ongoing monitoring plan for the provider network	
	Design process for collecting info on providers with closed panels (no new patients accepted) and those with access/accommodations for the physically disabled	Survey completed; information available in on-line provider directory
	Develop contracts (IGAs) with other departments	Completed.
CMS REPORTING		
General Financial Requirements		
AHS/OVHA shall comply with all general financial requirements under Title XIX. AHS must maintain financial records, including the following: 1) Monthly comparisons of projected vs actual expenditures; 2) Monthly report of OVHA revenues and expenses for Demonstration program; 3) Monthly comparisons of projected vs actual caseload, 4) Quarterly analysis of expenditures by service type; 5) Monthly financial statements; 6) All reports and data necessary to support waiver reporting requirements [IGA 2.12.2]	Document any modifications to current report formats that will be required	On-going
	Assign staff responsible for the production and submission of the required reports	Completed

Budget Neutrality Reporting		
For the purpose of monitoring budget neutrality, within 60 days after the end of each quarter, the state shall provide to CMS a report identifying actual expenditures under the Demonstration. [STC pg. 20]	Obtain report format from CMS	Still under discussion
	Make any necessary changes to reporting processes and procedures to accommodate the CMS-specified report formats	Still under discussion
	Assign staff responsible for the production of the reports	Completed
	Develop policies and procedures for the development of corrective action plans if actual expenditures exceed the levels permissible under the Demonstration STCs (by year)	Under development